Family Medicine and the Specialist Register

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It has indeed been an honour to serve again as MCFD President for two consecutive terms. When one thinks that one has spent nine years in all as President of the College one cannot but think humbly about members who have entrusted you to do so and I hope that I have satisfied them somewhat in what we have achieved - things which were mentioned in other editorials. Today I wish to speak about an ongoing issue which started during my tenure but which remain unresolved, although we have given our recommendations to issue a change in the law. We have spoken about this issue during several AGMs and also in this editorial but it is worth explaining the issue again as the law become clearer as we go along.

When the MCFD was put on the specialist register on its inception it was a great win for family practice in Malta. This specialist status really matters, especially for those who have been qualifying through the Specialist Training Programme in Family Medicine, which indeed has a thorough summative assessment. However, during these past years it has become evident that, although we are registered as specialists with the Medical Council of Malta, the law keeps us separate from other specialties - even sub-specialties which some family doctors also do, such as Occupational Medicine and Palliative Care. All these specialities are listed in section 1c of the law which lists every speciality for which the Medical Council issues certificates and which have their European certificate. Family Doctors have been put in section 1d to conform with other European states. This is basically a GP-register. The UK have the same thing but they refer to it as a GP-register as in fact it is. The only difference is that in the UK GPs are not listed as a specialty and therefore the GMC does not issue a certificate similar to ours. However the GMC *does* write on the specialist certification of other specialities, including Medicine and Surgery, that these latter are not allowed to practice as GPs or family doctors.

In fairness it has been recommended that we change the title of 1d to 'Specialist Family Doctors', rather than simply Family Doctors. I do however still have some reservation for this - at least until such time as we regulate general practice in the community. Doctors are still given a licence to be a 'medical practitioner' - which leave the practice of family medicine/general practice in a vague area when it comes to private practice. It is only in health centres and the MAM agreement imposes that recruits have to be on the Specialist Register. This is not so however for private practice, and any doctors with a licence continue to be allowed to practice. As we all know, in this day and age this is an issue about patients' rights. Once Family Medicine has become a speciality and across Europe one has to do some form of vocational training, then going out on one's own immediately can lead to dangerous practice. There is a difference between the organisation of courses today and those of twenty years ago, when courses used to aim the MD degree towards general practice. Family Medicine does not remain any longer a by-default work if one does not specialize in another area. The solution is to combine 1d into 1c and for the medical council to issue licences only to this category and prohibit people from working as family doctors or general practitioners privately without being on the register. This would also control the entry of foreign doctors into Malta; especially those who would work with a private hospital as a Family Doctor. If not what would be the point of being on the Specialist Register?

THE TRANSFORM PROJECT

On the other hand, whilst still President I was approached by Gabriella Calleja on behalf of the TRANSFORM EU project asking whether the college would like to partner in order to organise CME on how to treat people who are transsexual. These people may have different treatment modalities since they may be on hormones or other medication. Some may also need psychological support. GPs, as the primary contact need to know about these conditions. The project involves bringing GPs from the UK to give CME to College members. We will also include a new module in the existing curriculum for vocational training in this regard. The council had approved this and we are in the process of starting the project. The President asked me to be the MCFD's representative and council will be coordinating with the CME team to bring these activities to fruition.

THE STPFM CURRICULUM

I will continue to help the college as I can. The new President has asked me to continue editing the journal (JMCFD). This I am honoured to do: however I must thank the team including Drs Mario Sammut, Anton Bugeja and Glorianne Pullicino who do the major part of the work.

In the JMCFD the fruit of the STPFM is evident from the studies we have been publishing. Gone are the days when we craved for such studies to be done by our doctors. The studies from health centres are an invaluable source of information for doctors, authorities and to assess and audit the system.

The first article is an analysis of referral to social services in state primary care in Malta. The majority of patients referred are over 65 and one has to wait around 18 days on average, as the authors find. This 18 day wait period is difficult to interpret – whether it is a relatively short period of time considering the load of patients, or whether in point of fact it is too long compared to the service provided by the General Practitioners/Family Doctors themselves, who see patients immediately. One hopes that this system can be improved once centres such as the Paola hub to be built start operating.

The second study evaluates the use of nasal bone imaging in primary care in Malta. Indeed it highlights the limits of such x-rays as very few of those referred to ENT had fractures considering the 'substantial' number taken. Such study ought to spur revision of protocols, even considering the ethics of radiation exposure. With standards of care there will be no issue with malpractice or negligence; probably referral to ENT is mostly done anyway.

Finally a study on depression in Type 2 Diabetes in our primary care system illustrates the importance of screening for depression, which is more common than thought in these patients. Considering the importance mental health is taking on in primary care system world-wide, mental health care seems to be somewhat deficient internationally in general practice as the field has shifted to specialists. Conversely GPs are the first to see patients with mental health issues – they are indeed the primary contact for probably most cases in this regard – and it seems that patients not only prefer to be treated by their GPs but that it is becoming a myth to think that GPs can only treat minor to moderate depression[1].

Finally the new MFCD president asked me to continue to coordinate the revision of the curriculum. So I will not be taking that rest after all. I have made a list of topics which need revision and those interested in reviewing a module may contact me. There will be a remuneration from council.

Finally I wish to thank all for the great experience over the past six years. In total I have spend nine years serving the college and I hope that this was useful to many. When those of us who worked for the MRCGP(INT) see people graduating from the Specialist Training Programme (STPFM) and slowly increasing in their percentage as MCFD members, one feels the pride that family medicine in Malta is taking on more quality and prestige.

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1 Puschner, B. et al. "The epidemiology, burden, and treatment of mental disorders in primary care", in Andre F. Varvalho and Roger S. McIntyre (eds), Mental Disorder in Primary Care. A guide to their evaluation and management, Oxford University Press, UK, 2017, pp. 1-20.